A Professor 'Honorarius': *An Australian Experiment in Medical Administration 1939–64*

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THE HEADS OF THE GERMAN UNIVERSITY MEDICAL SCHOOLS OF THE LATE-nineteenth century who contributed richly to building the foundations of modern scientific medicine were entitled 'professor *honorarius*'. They were demi-gods and they had a counterpart in Australia.

During the 1950s and early 1960s hospital administrators travelled to the provincial city of Newcastle, New South Wales, to meet Dr C. J. McCaffrey, Medical Superintendent of the Royal Newcastle Hospital (RNH).[1] McCaffrey had developed a number of management systems designed to improve the hospital's efficiency. While some contemporary observers pronounced him a far-sighted pioneer in hospital administration, others thought he was fostering a dangerous Socialist plot.

McCaffrey believed that the management of most Australian hospitals was inefficient and that the needs of the patients were lost in the authoritarianism of the institutions and the ambitions of the medical staff. He would have supported the views of one hospital historian who wrote 'a hospital is, of all social institutions, the one in which perhaps the greatest mixture of motives, the most incompatible of ambitions and the most vexatious vested interests are thrown together'.[2]

In 1939, McCaffrey began an experiment in Newcastle Hospital (NH)—from 1949 known as the Royal Newcastle Hospital—to develop systems of administration, service organisation and medical care that were new to Australia. In so doing, he built an institution that focused primarily on the welfare of the patient; it was efficient, cost-effective and conducted with an awareness that the hospital was a publicly funded institution. McCaffrey concentrated on increasing the effectiveness of management through the creation of a unity of executive control and establishing clear lines of responsibility. Many of his innovations would eventually be adopted in other large hospi-

tals but, at the time, they defied the prevailing medico–political order and ignored current conventions of hospital management.

While much has been written about the development of public hospitals in Australia, the accounts have largely described the development of clinical services and the work of doctors as clinicians and researchers. There has been little analysis of how those hospitals were managed. This is partly because management was diffuse and largely a background activity. Hospital executives did not hold the powerful position they acquired later in the twentieth century.

This paper examines the strategies McCaffrey used to realise his vision for a new sort of hospital. His plans achieved a great deal of success despite the challenges posed by rapid developments in scientific medicine and a hostile medico–political environment. The experiment came to an unfortunate end in 1964, not so much from faults in the schemes but from human frailties.

Australian public hospitals

Throughout the first half of the twentieth century large Australian public hospitals, previously institutions for the indigent, expanded to provide more sophisticated services for patients of all social classes. The hospitals were nominally controlled by boards of management, but their policies were largely determined by the senior doctors, the honorary medical officers.[3]

The honoraries were responsible for the treatment of the patients and they used that role and their possession of expert medical knowledge to influence board decisions. They received no remuneration for treating public patients, but the positions gave them the privilege of admitting their own patients to the private beds in the public hospital and access to investigative and therapeutic resources that were generally better than in any private hospital. Honorary positions, particularly in teaching hospitals, were keenly sought because they also brought high professional status. Their place, however, in the organisational structure of the hospital was unclear. They were not employees and they had no formal contracts with the hospital, which allowed them a substantial degree of autonomy. Amongst themselves they also acted independently as they were competing outside in private practice. Such independence created difficulties for hospital administrators.

Other forces in the hospital were less influential. Nurses were the most numerous of the staff and their head, the matron, was often a very powerful figure, but her authority was largely limited to her own domain. In administration, the secretary/manager filled an accounting/ housekeeping role, while the medical superintendent was usually

a relatively junior doctor who had no jurisdiction over the honoraries. The lines of authority in the hospital were poorly defined, and increasing medical specialisation enhanced the problems.

Specialisation

During the twentieth century, and particularly following World War II, specialisation, driven by rapid advances in medical science and technology, dominated the development of medicine in Australia. Specialists needed access to the large public hospitals to acquire and maintain the knowledge and skills on which their professional status depended. The hospital was the specialists' workshop, offering them a large number of patients with a wide range of clinical problems, and providing expensive equipment and supporting staff.[4]

Hospitals also needed specialists to contribute to the development of services. Medical science and technology made possible advances in diagnostic and therapeutic processes, which demanded more of the specialists' intellectual energy and more of their time. It was no longer sufficient that they visit the hospitals two or three times a week, as previously, leaving most decisions to junior doctors with limited skills and experience. However, the honorary medical officers had other commitments as most were also in private practice, the only place where they could earn a living. This led to serious conflicts of interest for doctors between their obligations to their hospital appointments and their need for private work. The situation was unsatisfactory for hospitals, but most were forced to accept it because the honorary staff and the British Medical Association (BMA), NSW branch, fiercely opposed any changes to the honorary system. There were some administrators, however, who put the needs of the hospital and its patients first. One of these was Dr C. J. McCaffrey at Newcastle Hospital.

Newcastle Hospital / Royal Newcastle Hospital

Newcastle Hospital was established in 1817, at the mouth of the Hunter River, as a military hospital for the penal colony. It later became a hospital for the indigent and in 1932 a community hospital to serve the whole of the population.[5] With 350 beds by 1942, the institution provided the major services for Newcastle and the surrounding areas.[6] It was also a suitable size for a significant hospital experiment, and even a controversial experiment could be conducted with little effective external interference. For although Newcastle was the sixth largest city in Australia, its political and commercial development suffered

because it was not a State capital. The area attracted little political attention because both its Federal and State electorates were largely safe Labor seats. Newcastle was also distant from the conservative medical forces in the capital cities and their teaching hospitals. From necessity the city had long been accustomed to standing alone in meeting the needs of its citizens.[7] The city hospital, NH, had also shown a willingness to be independent.

The Starr period

In 1933 the NH Board of Management decided that the hospital should be more ambitious and provide medical facilities matching those of the metropolitan area. It appointed a Medical Superintendent, Dr Kenneth Starr from Sydney Hospital,[8] who was experienced in surgery and had shown an aptitude for administration. Starr fostered specialisation by creating specific honorary positions in, for example, surgery, gynaecology and internal medicine. Appointees practised only in their particular category and were expected to hold specialist qualifications. The hospital was 'closed' and no longer accessible, as were most community hospitals, to all the practitioners in the city.[9]

Starr recommended that the number of honoraries be reduced and that more resident medical staff be appointed to deal with all the medical emergencies and accidents occurring in Newcastle. From 1934 he personally practised both emergency and elective surgery, as well as his administrative duties.[10] The local medical practitioners and the BMA strongly opposed these moves. The doctors were concerned that they would lose patients, while the BMA said that by engaging in surgery Starr flouted its policies opposing salaried clinical services. In turn, Starr criticised the honoraries and fee-for-service medicine, which gave priority to private work at the expense of hospital responsibilities.[11] The hostilities between NH/RNH and the BMA lasted another thirty years. However, Starr's innovations, radical in medico–political terms, opened the way for McCaffrey's even more revolutionary measures.

Dr C. J. McCaffrey

In 1939, Starr resigned to join the army and Dr C. J. McCaffrey became Medical Superintendent of Newcastle Hospital. McCaffrey was then aged thirty-eight and had spent almost all of his professional career in the hospital. Appointed in 1927 as a Resident Medical Officer, he then became Resident Pathologist and later Resident Radiologist. Between 1932 and 1939 he often acted as relieving Medical Superintendent.[12]

McCaffrey had definite views about the future of NH. He told its Board of Directors in 1943 that the hospital should provide adequate care of the sick and the injured in terms of prevention, cure and rehabilitation. He predicted that NH would be the major hospital in Newcastle, with a regional role for specialist services, and that it would train resident medical staff and, significantly, specialists, and eventually the medical undergraduates of a future Newcastle university medical school. He emphasised that the needs of the patient had the highest priority, and rejected the view that the hospital was merely a workshop for doctors. For although doctors had a central place in the hospital, modern scientific medicine required a team approach if its full benefits were to be achieved.[13] McCaffrey believed, however, that the efficient operation of a hospital rested in the quality of management, with a unity of control being essential. The strategies he employed to create his vision of a modern hospital incorporated those views.

The possession of special knowledge

McCaffrey recognised that much of the power possessed by specialist doctors was derived from their monopolistic ownership of scientific medical knowledge, which gave them authority over boards of management and administrators. He believed that they had too much influence in determining the policies of public hospitals.[14] To strengthen his managerial position McCaffrey equipped himself with a broad knowledge of scientific medicine. While he could not be expected to retain the wide range of knowledge held by experienced physicians and surgeons, he was, nevertheless, informed enough to offer them a formidable challenge. He developed his knowledge by reading widely in most fields of medicine and was familiar with current English and German medical literature (he taught himself to read German). He could also claim some indeterminate knowledge, the knowledge that comes from experience and practice.[15] Before becoming Medical Superintendent, McCaffrey worked in pathology and radiology and had a close association with the clinical material in both fields. In radiology he was a consultant to all the medical specialties in the hospital. Although he lacked therapeutic experience his keen observations of the performance of others and their mistakes gave him authority. He could not only discourse freely with senior clinicians but also suggest to them innovative approaches to clinical problems.[16]

McCaffrey's knowledge gave him the legitimacy to provide expert advice on medical matters to the Board of Directors. Furthermore, he ensured that he was the directors' only source of medical information. He had arranged, in a manner which is not clear, to be the formal rep-

resentative of the medical staff to the board.[17] This was irregular; in most other hospitals one or two senior doctors attended board meetings as representatives of the medical staff association. The situation engineered by McCaffrey meant that his recommendations to the board were rarely obstructed by the medical staff.

Medical staff organisation

McCaffrey's priority was to appoint senior medical staff to carry out his designs for the hospital. He needed appropriately trained and formally qualified specialists who were sympathetic to his philosophies on hospital development. He believed that the honorary medical officers could not provide the level of services he required, as their available time was limited, they had unavoidable conflicts of interest, and their independence might cause him trouble. In 1946, all honorary positions were declared vacant and McCaffrey was able to appoint selectively suitable replacements.[18] He began by appointing full-time salaried specialists in a few key departments, for although he needed honoraries in certain smaller specialties, such as dermatology and ophthalmology, his aim was to have predominantly salaried medical staff. One quasi-salaried clinical position already existed. It was the post of Deputy Medical Superintendent, which had extensive duties in emergency and elective surgery as well as in administration.[19] In effect, this combined position had been filled from 1934–39 by Kenneth Starr.

McCaffrey recruited his first new staff specialists in the late 1940s and early 1950s. Fortunately there were interested, adequately qualified doctors available who were looking for new challenges in medicine. Disenchanted with what they had seen in the Sydney teaching hospitals as medical students and junior resident medical officers, they were disillusioned with the conservatism of the conventional teaching hospitals with their rigid hierarchical structures. Many were of mature age, having returned from war service, and all were interested in working in a new type of hospital. They anticipated being given clinical responsibilities that would not have come to them in a teaching hospital until they were much older,[20] and were willing, indeed enthusiastic, to join McCaffrey on his terms.[21]

The first new appointees were in anaesthesia, pathology and thoracic medicine. As the positions in anaesthesia and pathology were essential services that did not displace honoraries, they were grudgingly accepted by the BMA.[22] Thoracic medicine was also acceptable because the position involved looking after cases of tuberculosis, of little interest to doctors in private practice. While McCaffrey began cautiously, subsequent appointments presented much more of a chal-

lenge to organised medicine. The employment of salaried specialists conflicted with the policies of the BMA, which declared the honorary system the only suitable method of medical staffing for Australia. It resolutely opposed the appointment of salaried specialists, except in a few categories that did not compete with private practice.[23]

McCaffrey, however, took no notice of the BMA's objections and continued to employ whom he wanted, thereby effectively preparing the way for the appointment of medical staff who agreed with his views on hospital organisation. In 1943 the board accepted his recommendation that the hospital should engage in the training of specialists. In addition, he established that the trainees, the registrars, had an intrinsic but not always an automatic right to a specialist position on the staff.[24] Once registrars had shown they had fitted into the NH/RNH pattern, had completed their training period and gained higher qualifications, they were appointed staff specialists.

However, there was never a staff establishment plan. Specialists were appointed either as they became available or to meet certain needs. For example, Dr Holland, who had been a medical registrar, was appointed as a junior specialist because the hospital wanted to establish a service in internal medicine in nearby Maitland Hospital. Having become a Member of the Royal Australasian College of Physicians (MRACP), his specialist qualification, Holland was advanced to the status of full specialist.[25] There were at least fourteen specialists appointed in a similar manner between 1947 and 1963.

In appointing the first staff psychiatrist in 1955, McCaffrey again demonstrated his approach to recruiting compliant employees. With no existing psychiatric service in the hospital, McCaffrey had no internal applicants. However, he did not appoint an experienced specialist from outside to establish a new specialty, as many hospitals would have done, for he did not want anyone who might challenge his views. Instead he appointed as registrar a newly qualified psychiatrist on a six-month provisional appointment. Having been judged suitable for RNH, he was offered a permanent staff specialist position.[26]

McCaffrey also ignored the conventions followed by the large hospitals in the rest of the State for making specialist appointments. He rarely advertised positions and applicants were not scrutinised by selection committees. Instead, they were appointed by the board on the direct recommendation of McCaffrey, who might occasionally consult the director of the relevant department. In other large hospitals candidates appeared before a selection committee that usually included external members, often from the University of Sydney. The recommendations of this committee were then reviewed by the Medical Appointments Advisory Committee of the Hospitals Commission of NSW. The NH/RNH, however, did not consult this advisory committee.[27]

McCaffrey's methods of appointing staff specialists ensured that he had a senior medical staff that supported his views. Even if they did not, there were few mechanisms for objection. The staff specialists were employees, not independent like honoraries, and answered to the Medical Superintendent—an important component of his strategy of unity of control. Although McCaffrey's processes of recruiting staff were criticised, his individual selections were sound. His appointees were successful within the hospital, and many were recognised externally for their abilities by their election to prominent positions in the medical and surgical colleges and State and national organisations.[28]

McCaffrey acknowledged that his full-time staff specialist scheme was not original. The foundations of the scientific medicine of the twentieth century had been laid down by salaried doctors in French and German university hospitals in the nineteenth century.[29] Of more direct relevance was the work of William Henry Welch in Johns Hopkins Hospital and University in Baltimore, USA, in the early twentieth century. Welch introduced the system of appointing full-time salaried medical staff, which made possible the creation of a first-class hospital and research establishment. His model was adopted across the USA making that country the world leader in scientific medicine.[30] McCaffrey freely acknowledged his debt to Johns Hopkins.

Executive roles for clinicians

McCaffrey believed that his concept of unity of control could also be applied at a departmental level. He delegated managerial authority to certain doctors, titled directors, who assumed executive responsibilities for running their own departments and to whom the members of the department were answerable. It was a new concept for clinical services in Australia. Like many of McCaffrey's plans it conflicted with the BMA policy designed to protect the honorary system, in which all doctors were equal with equal rights in regard to making departmental decisions. The policy stated that positions such as chief of staff or clinical service director were unacceptable, except under certain rare situations, for example, in a new department in a teaching hospital.[31]

The RNH's department of anaesthesia and the operating theatres was the first to have a full-time director, Dr Ivan Schalit, and was one of the few positions to which McCaffrey appointed a senior person. Central to the surgical services, the department used expensive resources and was an area of confused and conflicting authority. Schalit was given control of the allocation of the resources within the theatre and held administrative authority.[32] And, as he was already well qualified and experienced in his specialty, surgeons were obliged to deal directly with

a doctor of equal professional status. Prior to this the surgeons, who had always had the highest status in the area, had been dependent on the senior nurse in charge for their access to operating space and time. The anaesthetists, who had previously been largely the servants of the surgeons, had also risen in status and power. Science and technology had made them equal partners with surgeons in modern surgery.

Another clinician with considerable authority over his peers was the Deputy Medical Superintendent and director of surgery, Dr J. J. Smyth, who was delegated to monitor and control the admission and discharge of patients in all beds in the hospital. Smyth ran the Bed Supervisory Office and brought pressure to bear on his colleagues to manage beds efficiently, particularly in the planning of patient discharges. He could impose penalties for non-compliance, and doctors could have their admission privileges removed if they did not cooperate.[33] By the end of 1957, directors had been appointed in general medicine, respiratory medicine, surgery and orthopaedics,[34] and most departments had directors by 1965.

Quality control

In virtually all Australian hospitals before the 1960s, the quality of care provided to patients by the senior medical staff was not monitored. Hospital boards, which were ultimately responsible for the conduct of the hospitals, had no assurances that the medical staff was securing results that conformed to reasonable standards, or that each patient was being treated with the degree of efficiency and safety they had a right to expect. Although most doctors in the large public hospitals were conscientious, they functioned as individuals and peer surveillance was rejected. Nor were medical administrators permitted to interfere in clinical matters.[35]

McCaffrey's concern for the welfare of the patients led him to introduce systems of quality assurance, which also served as a mechanism of control. He began by improving the quality of the patients' medical records—the main source of information about clinical processes—and the adoption of a uniform nomenclature of disease. The patient's diagnosis was noted on the record chart with an indication of the outcome of the treatment received. A doctor prepared a summary of the admission events and a copy was sent to the patient's general practitioner.[36] McCaffrey also introduced dictating machines to facilitate the recording of clinical information quickly and thoroughly. The machines were first installed in the pathology and radiology departments, and later in the operating theatres and medical records department. Dictated material was typed by clerks well-trained in medical nomenclature in

the clerical training school, another of McCaffrey's innovations.[37] In the field of quality control, McCaffrey was a pioneer in Australia.

The improved and prompt system of documentation allowed for the commencement of audits of surgical procedures in 1953. The surgeon's reason for recommending an operation was set against the results of the pathological examination of the tissues removed (it was mandatory for removed tissues to be sent to pathology), and the data discussed in meetings of the surgical and pathology staff.[38] Auditing of all departments' clinical work became more feasible when the hospital joined the Professional Activity Study of the W. H. Kellog Foundation in Ann Arbor, Michigan, USA. Clerks in RNH extracted data from the patients' charts, which was correlated and analysed in the USA and returned to Newcastle in a printed format for further examination.[39]

Weekly clinico-pathological meetings, 'the death meetings', were held from 1953 onwards to discuss the cases of patients who had died and to review their autopsy findings. The hospital had an autopsy rate of 80 per cent, which was considered highly creditable at the time. McCaffrey and all the salaried medical staff attended under strong peer and administrative pressures. These meetings were intended to be of an educational nature but there was a danger they could become inquisitional. Indeed, some believed that they were unfairly criticised by participants at the meeting. Outside doctors also voiced complaints when they discovered that their treatment was being censured without them having been provided with an opportunity to defend their actions.[40]

There were other forms of performance surveillance too. Requests for intravenous infusions of fluid and electrolytes and blood transfusions were directed to a clinical pathologist as a consultation, and doctors were obliged to justify these requests. Such a process provided a second opinion on procedures that might be hazardous or expensive. The results of microbiology and other pathology tests were also closely monitored by the clinical pathologists. This system permitted the development of uniform standards across the hospital, and a method of quality surveillance which provided data that was then accessible to other members of the department, to the director and, ultimately, to the Medical Superintendent.[41] An outside observer, who had been involved in BMA-sponsored quality assurance programs in Australia, said that RNH was light years ahead of any other hospital in quality assurance.[42]

Nursing

In RNH the matron, the head of the nursing service, was administratively responsible to the Medical Superintendent, a relationship that had been determined by the board of directors in 1937 during the super-

intendency of Kenneth Starr.[43] From long tradition, nursing was administratively separate from the rest of the hospital and had a rigid hierarchical structure that was very resistant to change. Such a situation presented a challenge to a reforming hospital administrator who wanted the nursing service better integrated into the hospital and more closely under his control.

A particularly strong nursing unit was the hospital ward. This was controlled by the ward sister who was the mistress of the household. Responsible for the efficient running of the ward, she retained a considerable degree of independence and contributed to the training of the student nurses working under her. The large number of wards in the hospital, and the different standards and approaches to ward management and to nurse training, made effective administration difficult.[44]

McCaffrey requested that the matron establish a dedicated nurse education program to replace that of the ward sisters. This new department, staffed by tutor sisters who introduced uniform teaching programs, allowed for the development of standardised nursing methods and techniques that then operated throughout the hospital. This meant that the Medical Superintendent could monitor nursing training and promote coordination with other departments.[45]

The wards, which functioned independently, were reorganised to handle the admission of new patients more efficiently. Previously, there had been set admission days when patients were admitted to a ward under the care of the honorary medical officer who 'owned' the beds in that particular ward. This, however, had led to some of the wards being overcrowded and the nursing staff overworked, while adjacent wards were relatively idle. McCaffrey established ward groups—for example, of medical, surgical and gynaecological beds—and patients were admitted to an appropriate available bed. This spread the workload for the nursing staff more evenly and they worked more cooperatively.[46] The doctors were also affected, to the advantage of the administration. They no longer 'owned' their specific number of beds, which reduced their control of scarce hospital resources. It also meant a reduction in status, as bed ownership had in the past been the prerogative of the most senior specialists.

Patient care was further rationalised by the creation of a recovery and intensive care ward. Here the more seriously ill patients could be treated by specially trained nurses and their equipment could be concentrated. This area came under the control of the Director of the Operating Theatres, another extension of the unity of control.[47]

McCaffrey held that nurses were valuable resources and that the hospital should have the full benefit of their professional skills. Traditionally, nurses had been involved in a number of duties—for example, serving meals to patients, clerical tasks, acting as couriers,

and various cleaning and housekeeping chores—that could more economically be performed by others. McCaffrey allocated these duties to lower paid clerical and domestic staff, thereby reducing the numbers of nurses employed.[48] However, many nurses regretted the loss of their traditional roles, and thought that the hierarchical structure of nursing had been disturbed by giving the lowly duties of cleaning walls and sinks, previously relegated to the most junior nurses, to non-nursing staff. A senior nurse claimed that the foundations of nursing were threatened in RNH, because nurses had been stripped of their power and responsibilities. But nurses also gained status under McCaffrey's policies. Senior nurses were sent on management courses and met regularly with McCaffrey to discuss nursing organisation and education. And with their enhanced professional roles, nurses became relatively much less subservient to doctors.[49]

McCaffrey kept as tight a control on the appointment of senior nurses as he did on that of doctors. On the selection of an internal candidate for the position of matron, he said:

> We have affected probably more reforms in nursing than in any other Australian hospital. Nursing administration has radically altered. There is still a long way to go… It would be a tragedy at our stage of development to get someone who knows little of the history of what we are doing and who might try to put a brake on what is happening. Miss Porter (who was appointed) will carry along the present policy quite well.[50]

The dietary department

McCaffrey's innovative changes extended beyond the medical and nursing staff. He believed that nutrition and the supply of food were important issues in patient care. The dietary department, which had been established by Starr, provided the most specialised of the non-medical activities in the hospital. McCaffrey expanded and strengthened the department, and employed science graduates with diplomas in dietetics to act as nutritional consultants. They planned the composition of meals for all the patients and formulated diets for those with special needs, for example, patients with diabetes or coeliac disease. A staff specialist, a gastroenterologist, supported the dietitians and provided a monitoring process which ensured that requests from doctors for special diets were justifiable, another form of clinical surveillance. The gastroenterologist was accorded the right to question doctors' requests.[51] The dietitians were in charge of the kitchens and employed dietary aides to serve food in the wards, taking the task from the nurses.

The head dietitian reported directly to the Medical Superintendent, which brought a unity of control to a major service with duties throughout the hospital.

Imprest systems as management tools

McCaffrey referred to imprest systems as tools of management that improved efficiency and allowed better surveillance of critical hospital activities. He introduced imprest systems for the supply of various goods to the wards, operating theatres and outpatient departments. Prior to their introduction, the nurses in charge ordered supplies and controlled their distribution from multiple locations across the hospital.

Bed linen, for example, had been a particular problem. Wards tended to hold large supplies of bed linen in cupboards beyond the effective reach of any central accounting and control system. To counter this, McCaffrey established laundry as a separate service responsible to hospital executives through the supply services. After investigations had established the daily usage of linen, the staff of the laundry delivered only what was needed for the following twenty-four hours. The new system resulted in better control of the use of linen and prevented wasteful hoarding.[52] Other imprest systems were also implemented. The pharmacy used them for the distribution of drugs to the wards and outpatients department, while the stores department used them for the supply of stationery.[53]

A central sterilising system

McCaffrey also developed a centralised system for the sterilisation of instruments, dressings and other materials. Previously these procedures had been carried out in the wards and operating theatres, but with the need for more stringent quality control this became no longer efficient or safe. The Central Sterilizing Department (CSD) was under the control of a graduate in bacteriology, who reported directly to the Medical Superintendent. The functions of the department included cleaning instruments, autoclaving, chemical sterilisation and the packaging of the sterile products. All were processed in an industrial manner on an assembly line, and users were provided with the materials on an imprest system.[54]

McCaffrey used the CSD for clinical surveillance, as he was concerned about the problems of hospital-acquired infection. He believed that the inappropriate use of antibiotics was an important cause of such infection and sought to limit their use. He gave the CSD respon-

sibility for the storage and dispensing of both oral and parenteral antibiotics, usually the role of the pharmacy. McCaffrey believed that the CSD and its manager, who was under his control, provided a better means of monitoring antibiotic usage than the pharmacy. The CSD collected data on how doctors ordered antibiotics, along with their reasons, and sent reports to the clinico-pathological meetings where they were critically examined.

McCaffrey and the Board of Management

The Board of Management was the body responsible for the proper conduct and performance of RNH. Board members were appointed by the Minister of Health, ostensibly to represent the people of the region. There were, however, no doctors on the board, a policy established by the New South Wales Hospitals Commission which covered most public hospitals. McCaffrey acknowledged the governing role of the board but believed that it lacked skills in hospital administration. He knew that boards elsewhere had thwarted the efforts of chief executive officers and interfered with processes of management. Some board members pursued their own ambitions, and often the medical staff had too much influence.[55]

McCaffrey was firmly convinced that if a hospital was to be efficiently managed there had to be a unity of control with the chief administrator in charge;[56] he did not want his authority to be challenged by anyone. Using his knowledge of medical matters, his skills in business management and his dominating personality, McCaffrey was usually able to persuade the board to support his recommendations. He had also gone to great lengths to ensure that he was the only medical adviser to the board.

With the establishment of the staff specialist system there were relatively few honoraries on the staff of RNH. However, McCaffrey sought to further reduce any risk that these independent practitioners might adversely influence the board by ensuring that their number remained small. Thus, although RNH had the best facilities for patient care in Newcastle—usually an attraction for specialists in private practice to join the staff—McCaffrey discouraged them from joining the hospital by refusing to have special wards set aside for their private and intermediate patients.[57] He instituted the one doctor, one hospital policy, which dictated that honoraries on the staff of RNH were not allowed to have a similar position at another public hospital. As a result, a number of doctors chose to abandon their attachment to RNH, although others did stay on, prepared to tolerate McCaffrey's authority. The policy created further serious rifts between the hospital and

the medical profession in the city. The BMA intervened but could not convince the board or the superintendent to repeal the policy.[58]

McCaffrey sought to diminish the credibility of the honoraries and their representative body, the BMA, in the eyes of the board members. He told them he suspected that certain honoraries and other doctors outside the hospital had inferior clinical skills and dubious ethical standards. He also voiced his poor opinion of doctors who engaged in fee-for-service private practice; they were, he argued, self-serving and only interested in making money. McCaffrey claimed that many doctors were guilty of carrying out unnecessary operations and were, therefore, reluctant to participate in surgical audits that would reveal 'their unsavoury work'. He informed the board that 'a surgeon received three guineas for an honest opinion, and fifty guineas for an operation'.[59]

McCaffrey convinced board members (and the staff specialists) that RNH was under siege, and that the innovative practices developed at the hospital were being attacked by ignorant conservative medical forces in Newcastle and Sydney. He claimed that his staff specialists were often unfairly criticised for their clinical enterprises. His aim was to create a closely knit institution, with the board, the superintendent and the staff specialists isolated but united against a hostile medical world.[60]

Until near the end of his superintendency the board repeatedly expressed confidence in McCaffrey and his methods of administration. For example, in 1953 it strongly reaffirmed its support of his recommendation to employ full-time medical staff.[61] In 1960 it noted that '(McCaffrey) is the CEO… to him is owed to a great degree all that been built up at RNH'.[62] But by early 1964 the tone of the board's minutes began to change, and adverse comments about McCaffrey's management style were recorded. Up until that time, however, he dominated the board.

McCaffrey's achievements

McCaffrey developed hospital management systems that were unique in Australia. More than twenty years later their validity has been endorsed through their adoption as standard practices in many hospitals. By placing the welfare of patients first, McCaffrey assigned the medical staff to a position in which their professional ambitions took second place to patient care. For his chosen staff specialists that was not a problem. Until the early 1960s most of them worked at RNH with professional satisfaction, developing and delivering valuable clinical services. Between 1949 and 1964 thirty-two staff specialists came to Newcastle because they wanted to work in McCaffrey's hospital.

Many stayed through much of that period, while others left to go into private practice or other positions. There were, however, a few who could not tolerate what they saw as McCaffrey's 'brain-washing', and left.[63]

McCaffrey successfully established the staff specialist system in the face of intense opposition from organised medicine, which ultimately had to acknowledge that 'the full-time' specialist was necessary to develop a modern scientific hospital. Under McCaffrey's guidance his staff specialists developed a number of clinical services—including the treatment of diabetic coma and peptic ulcers and geriatric care—that came to be generally accepted, although some were, at first, contrary to prevailing practices. McCaffrey also set up programs that measured the quality of the services provided by the medical staff, and in this field he was a leader in Australia.[64] In addition, he developed programs of training for junior medical staff. The high quality of these was acknowledged by the large numbers seeking appointments and through the endorsement of the Post Graduate Committee in Medicine based in Sydney.[65] The programs produced both well-trained general practitioners and doctors who would fit McCaffrey's criteria for employment as staff specialists.

Moreover, McCaffrey was a pioneer in the application of business and commercial methods in the running of a hospital in Australia. He had closely studied the subjects himself and employed consultants who assisted in the development of many of his initiatives, including the Central Sterilizing Department, the imprest systems, the organisation and processing of medical records, and the management of the operating theatres.[66]

McCaffrey received external recognition as a medical administrator, and was invited to be a member of the Board of the Benevolent Society of NSW and the Royal Hospital for Women, Sydney.[67] Malcolm T. MacEachern, a professor of hospital administration from Northwestern University, Illinois, USA, who visited RNH in 1953, described McCaffrey as one of the finest hospital administrators in the English-speaking world.[68] McCaffrey had built a hospital that provided an efficient and economical health service for the people of Newcastle, an achievement acknowledged by an editorial in the major Newcastle newspaper which said RNH was always highly esteemed in the community it served. Newcastle residents were proud of their institution because it was progressive and distinctive, and attracted praise throughout Australia and abroad.[69]

McCaffrey's hospital was frequently deemed to be a socialist institution, a judgment of praise by some but a damning accusation by others. While McCaffrey admitted it could be seen to be so, he was not a socialist in a politcal sense.[70] After the end of the experiment at RNH,

the Liberal Leader of the Opposition in the NSW Parliament, R. W. Askin, claimed it had been an expensive exercise in socialist medicine launched by the Labor government.[71] However, all the evidence suggests that the experiment was conceived and carried out by McCaffrey alone. A board member, writing in a celebratory book published by McCaffrey's admirers, stated that:

> The central figure in the evolution of RNH was McCaffrey… [he created] a most dynamic institution in which nothing that happened was not under constant medical, financial and administrative review, with McCaffrey involved at the centre of the action, on all fronts.[72]

However, eventually problems developed which brought his governance and his experiment to a close. In 1964 the NSW Minister of Health dismissed the board of directors and appointed an administrator. McCaffrey was set to one side and resigned a year later. A number of factors contributed to the end of his notable career, prominent among them were serious flaws in his character.

McCaffrey, the man

McCaffrey had a commanding presence both physically and intellectually. He was flamboyant, stimulating and confronting. Both his admirers and his enemies—and he made many of both—agreed that in his prime he was an outstanding leader and team-builder. His depth of knowledge of medicine was exceptional. An excellent teacher, he used a dialectical approach, and was considered most skilful in guiding his medical staff to solve organisational and clinical problems for themselves. He was persuasive and very good at putting thoughts into people's heads.[73] However, he ruled with a rod of iron and was quite inflexible. Often rude, irritable and subject to violent outbursts of anger, McCaffrey would not tolerate any deviation from his policies, and those who came to question them were obliged to leave the hospital. He was a person who people either loved or hated.[74]

On the evidence of board members McCaffrey was unscrupulous in circumstances which he considered critical to his maintenance of control. The board complained that they were not fully informed about vital hospital events, and that the minutes of their meetings were censored by the medical superintendent, with some even rewritten in a way favourable to McCaffrey. The chairman, however, signed the minutes as correct because he was dominated by McCaffrey.[75] It is significant that in the middle of 1962 the board requested a stenographer attend board meetings.[76]

McCaffrey was unforgiving and unjust to his critics.[77] His suspicious nature lost him many of his previously faithful friends, a loss he did not seem to care about, and made him many bitter enemies.[78] Yet one staff specialist described him as gentle, shy and gallant—but, nevertheless, rude—and said that he and his colleagues were, with some exceptions, 'a cohesive family, like a group of favoured sons with McCaffrey the father figure'.[79]

In 1960 McCaffrey's private life changed dramatically when his wife died in tragic circumstances. She had been a source of great strength to him, providing softness and stability in his relations with the people around him, including his staff specialists. Following her death he was extremely lonely, and in 1963 he married again.[80] It was during these few years that McCaffrey's associates noticed changes in his personality which adversely affected the running of the hospital.

The RNH dispute

In the early 1960s tensions arose between McCaffrey and the board, particularly over unresolved problems about the staff specialists' rights of private practice. Another serious dispute concerned a board determination that all patients who attended the outpatients department and casualty should be seen by a specialist. The service was never effectively established: the board blamed McCaffrey and he blamed certain staff specialists.[81] Board members began to question their previous trusting relationship with McCaffrey, with one declaring that 'until the last few months the board has always been a rubber stamp'.[82]

Among the staff specialists, two factions emerged. Some remained loyal to McCaffrey, and accused the deputy superintendent of plotting to overthrow him.[83] But others were concerned both about his performance in management and that his personality had changed, using words such as paranoic and schizophrenic to describe his behaviour. There were a number of bitter disputes with staff specialists who had previously been his friends and admirers.

In this disturbed environment McCaffrey became subject to a serious conflict of interest. Throughout his time at RNH, he had imposed strong ethical principles and standards of clinical practice on his medical staff, which they had willingly accepted. In particular, he had advocated the sparing use of antibiotics and opposed unnecessary operations. However, McCaffrey's new wife, Dr Doreen Birch, an ear, nose and throat surgeon who had been appointed a staff specialist in 1962, used antibiotics liberally. She also frequently performed tonsillectomies, which McCaffrey included in his list of unnecessary and dangerous operations. Birch had even carried out the operation on seven

members of the one family in a week.[84] One of the few staff members to come from outside the hospital, she did not undergo the usual period of induction into the philosophies of RNH and ignored many of her husband's principles.

The immediate event that brought about the board's dismissal and McCaffrey's removal from power came when Birch asked her husband to dismiss her registrar, which he did. Birch claimed that the registrar had failed in his duty by not informing her about certain problems with one of her patients. However, a number of staff specialists and some board members considered Birch to be in error, and McCaffrey's actions unfair and unethical as he should not have sat in judgment on a matter which involved his wife. The episode widened the existing divisions within the hospital and the board, unable to resolve them, was discharged by the Minister for Health.[85]

There were other circumstances, too, that contributed to McCaffrey's demise. Chief among them was that he no longer held the authority of unique knowledge, one of his most useful means of control. The rapid advances in medical science during the 1950s and 1960s made it impossible for one person to keep up to date, even a person as energetic as McCaffrey. Some of his staff began to question his previous claims to knowledge, suspecting that he used the information derived from his extensive reading either selectively or with bias. They suggested he chose that which supported his arguments, and rejected that which conflicted. A particular example concerned the care of premature infants. McCaffrey had rigid views on the care of new-born babies, believing they should not be artificially warmed, nor that infant incubators be used. He never revealed the source of the data supporting his views, but was fixed on non-intervention despite well-established scientific data showing that careful warming increased infant survival.[86]

The problems at RNH were enhanced by its self-induced isolation. Sir Theodore Fox, editor of *The Lancet*, visited Newcastle in the course of a tour of Australian hospitals. He later recorded that although the RNH was a model of an efficient State institution, it was also 'an isolated professional enclave at great risk of persisting with obsolete and irrelevant policies'.[87]

The Hospital Commission inquiries

The Hospitals Commission of NSW held an inquiry into the circumstances leading to the dismissal of the board. However, the commission investigators were not able to determine clearly any single cause of the problems. While they acknowledged McCaffrey's abilities and his contribution to the development of RNH, they found he had

assumed powers greater than he should properly have possessed. The board, too, was at fault for allowing this situation to arise. The investigators stated that the board had little appreciation of its proper function and should have set up committee systems, including a medical advisory committee, to broaden its access to information without which it could not make balanced management decisions.[88]

Throughout the inquiry, many staff specialists became emotionally distressed by the investigators' questions. They seemed so disturbed by the events that they could not offer, quietly or rationally, any clear explanation of what had happened. It was as though a previously united family had disintegrated in a distressing divorce.[89] A specialist loyal to McCaffrey claimed that the breakdown was inevitable and that the system of management would have collapsed, even without the episode precipitated by Dr Birch. The hospital had grown too big and unstable.[90] There were then multiple causes for the conflicts in RNH, some related to changes in medicine itself, some to the institution and some to the flaws in McCaffrey's character.

One can speculate that the model McCaffrey chose for NH/RNH, and his own career in medical administration, was the German hospital medical school of the nineteenth and early twentieth centuries. Such schools were powerful and relatively autonomous, with doctors paid by the state and thus not dependent on students' fees or private practice. This left them free to pursue their scientific and clinical careers in an environment in which strong entrepreneurial and competitive spirits were encouraged.[91] In particular, the head of a school—the professor *honorarius*—was 'a lord within his own kingdom', which would have provided an irresistible model for a man with such an obsession for control.[92] It has also been claimed that the German schools were successful because they were led by outstanding personalities with the capacity to build institutions in which collaborative work could occur.[93] By these criteria McCaffrey could be well satisfied that he emulated his model. However, he failed sadly when it came to engendering disciples to continue his creative work. He also failed because he did not disseminate his ideas, which was unfortunate as he had a broad knowledge of medicine and long experience in hospital administration. McCaffrey had much to offer Australian medicine yet he published virtually nothing.

Abraham Flexner, the American educator commissioned by the Rockefeller Foundation in the early twentieth century to inspect medical schools in the USA, Canada, the UK, and Europe, commented adversely on the role of authority in the German schools. He believed that the rigid hierarchical structure would not be acceptable in the USA and Britain, and was counter-productive to effective research. In addition, having the professor as demigod with too much power often left

junior staff very unhappy in their work.[94] Flexner's remarks are apposite to Australian medicine, where doctors were also highly antagonistic to such authority. It is not surprising that McCaffrey's experiment in control foundered. That it worked for a time was due to his skills of persuasion and a group of disciples willing to explore new ways of providing better medical care.

Conclusion

In a period of fifteen years McCaffrey took the NH/RNH from a provincial hospital, staffed largely by general practitioners, to an organisation with the most advanced administrative systems in Australia offering specialist medical and surgical services oriented to the needs of patients and to efficiency and cost-effectiveness—bywords in public hospitals at the beginning of the twenty-first century. The German model and the concept of unity of control were effective in the early stages of development, and in forging a cohesive system of medical staffing. However, they did not work as the hospital grew larger and the staff specialists matured professionally, outgrowing their dependence on their hospital 'father'. Nor was the German culture of discipline and control appropriate in Australia. McCaffrey failed personally when he abandoned the strong principles for which he was admired and often feared. The mixture of motives, incompatible ambitions and the vexatious vested interests, combined with the human flaws of the creator of the hospital, were sufficient to cripple it for a time. However, many of the innovative systems developed by McCaffrey endured long after his departure from the Royal Newcastle Hospital.

Newcastle

1. H. M. Douglas, Letter to author, 31 January 1995. Douglas was Medical Superintendent of the Adelaide Children's Hospital from 1954–59 and visited RNH in 1957 with a group of hospital administrators. There were also visitors from, for example, New Zealand, Melbourne and elsewhere who came to see the central sterilising service, the dietary service, the imprest systems, the stores and other services. NH/RNH Board of Directors Minutes (hereafter BM), 6 December 1955, 7 February 1956, Archives, Auchmuty Library, University of Newcastle, Newcastle.
2. J. Langdon-Davies, 'Westminster Hospital, London, 1952', in Geoffrey Rivett, 'Hospital Histories', *Social History of Medicine*, vol. 6, issue 3, 1991, pp. 429–37.
3. The honorary system in most Australian public hospitals lasted until the introduction of Medibank after 1974. Anne Crichton, *Slowly Taking Control: Australian Governments and Health Care Provision 1788–1988*, Allen & Unwin, Sydney, 1990, p. 148.
4. George Rosen, 'Whither Specialization', in The American Philosophical Society (ed.), *Medicine and Society: Contemporary Medical Problems in Historical Perspective*, The Society, Philadelphia, 1971, pp. 196–291.

5. BM, 6 January 1932.
6. NH/RNH served a population of 150,000 in the 1940s increasing to 250,000 by the 1960s. In 1963 the hospital had more than 500 beds.
7. J. C. Docherty, *Newcastle, The Making of an Industrial City*, Hale & Ironmonger, Sydney, 1983, pp. 163–6.
8. BM, 6 June 1933; W. H. Neild, 'The Authoritarian Colossus of the 1930s', in John Lewis (ed.), *Reminiscences of the Royal*, The Royal Newcastle Hospital Heritage Committee, Newcastle, 1997, p. 16. Kenneth Starr was later a senior surgeon at Sydney Hospital and president of the Royal Australasian College of Surgeons.
9. BM, 15 May 1934; 16 March 1937.
10. BM, 13 January 1933; 20 July 1937.
11. BM, 15 May 1934; 20 July 1937; 18 July 1939.
12. Resident Medical Officer position, BM, 25 October 1927; Resident. Pathologist, BM, 30 July 1929; Resident Radiologist, BM, 21 July 1931.
13. BM, 3 March 1943; 7, 20 April 1943; 18 May 1943; 25 September 1943; 7 May 1946.
14. For a discussion on the place of knowledge in professionalisation see H. Jamous & B. Peloille, 'Professions or Self-Perpetuating Systems? Changes in the French University-Hospital System', in J. A. Jackson (ed.), *Professions and Professionalization*, Cambridge University Press, Cambridge, 1970, pp. 111–52.
15. J. M. Duggan, 'McCaffrey's Character and Charisma', in Lewis (ed.), *Reminiscences*, pp. 72–7; J. M. Duggan, *ADB*, vol. 15, p. 161; J. M. Duggan, 'Chris McCaffrey, A Pioneer of Quality in Health Care', *Journal of Quality in Clinical Practice*, vol. 17, 1997, pp. 155–62.
16. Peter Hendry, interview with author, Newcastle, 9 April 1995. Hendry was a clinical pathologist and director of the Blood Bank, 1947–56.
17. It has been suggested that during World War II, when the few doctors of RNH not on military service were very busy, McCaffrey offered to represent the medical staff association, a position he never relinquished. J. M. Duggan, personal communication, 2002.
18. BM, 3 September 1946.
19. John Smyth, 'A Unique Post-Graduate School of Medicine', in Lewis (ed.), *Reminiscences*, pp. 83–5. The Deputy Superintendent/surgeons were W. H. Neild, 1939–46, N. Newman 1946–55, John Smyth 1955–64.
20. R. M. Mills, interview with author, Newcastle, 29 May 1998; R. M. Mills, 'A Host of Milestones in Chest Medicine', in Lewis (ed.), *Reminiscences*, pp. 57–61.
21. Hendry interview; Leo Butler, 'Chris McCaffrey: An introductory memoir', in Leo Butler (ed.), *Chris McCaffrey A Great Administrator: A Memorial Collection by his Colleagues*, The Hunter Valley Research Foundation, Newcastle, 1985, pp. 20–3. Butler was a journalist with the *Newcastle Morning Herald and Miners' Advocate*. He had a close relationship with McCaffrey and attended NH/RNH Board meetings. He wrote many articles in that newspaper as an apologist for RNH.
22. BM, thoracic physician (Byrne), 18 February 1946; anaesthetist (Schalit) and pathologist (Douglas), 6 May 1947.
23. BMA/NSW branch, Hospital Committee minutes, 24 April, 24 June 1953, BMA/AMA records, Mitchell Library, Sydney.
24. BM, 25 September 1943; 1 February 1949.
25. BM, 25 October 1960; 3 May 1962.
26. BM, 16 March, 20 April 1954; 7 June, 5 July 1955.
27. BM, 18 April 1950.
28. Duggan, ''Chris McCaffrey, A Pioneer of Quality', pp. 155–62. For example, R. M. Mills became president of the Thoracic Society of Australia, Gordon Kerridge the president of the Australian Orthopaedic Association, and Peter Hendry, president of the Association of Societies of Pathology.
29. W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge University Press, Cambridge, 1994. pp. 92–114.

30. Simon Flexner & James T. Flexner, *William Henry Welch and the Heroic Age of American Medicine*, Viking Press, New York, 1941.
31. BMA/NSW Branch, House Committee Minutes, 25 July 1961.
32. BM, 22 October 1946; 6 May 1947. Ivan Schalit graduated in Medicine in Melbourne in 1936 and served in the Royal Army Medical Corps in the UK as an anaesthetist during World War II. O. F. James, 'A Tide of Talent and Innovation', in Lewis (ed.), *Reminiscences*, pp. 33–7.
33. Smyth, 'A Unique Post-Graduate School of Medicine', in Lewis (ed.), *Reminiscences*, pp. 83–95.
34. BM, 3 December 1957.
35. Edward S. Stuckey, 'The Staffing of Public Hospitals', *Medical Journal of Australia*, no. 1, 1961, pp. 890–4. Stuckey was president of the BMA (NSW branch).
36. BM, 19 July 1949.
37. BM, 3 February 1947; Smyth, 'A Unique Post-Graduate School of Medicine', in Lewis (ed.), *Reminiscences*; Laurel Windross, 'The Typing School', in Butler (ed.), *Chris McCaffrey*, pp. 251–62. Windross was the head of the Clerical Training School.
38. Duggan, 'McCaffrey's Character and Charisma', in Lewis (ed.), *Reminiscences*, pp. 72–7; Duggan, ''Chris McCaffrey, A Pioneer of Quality', pp. 155–62.
39. BM, 21 January 1960; 7 May 1963.
40. Barry Chapman, 'Resident Training in Royal Newcastle', in Butler (ed.), *Chris McCaffrey*, pp. 151–67.
41. Hendry interview.
42. Lionel Wilson, telephone interview with author, Sydney, 23 July 1997.
43. BM, 19 October 1937. In many hospitals the matron was responsible to the board.
44. C. J. McCaffrey, Functional Management in a Hospital, paper presented to a seminar on administrative studies at the Australian National University, 15–17 August 1963. Historical collection, RNH Library, Newcastle.
45. ibid., pp. 9, 10.
46. ibid.
47. Ivan Schalit, 'The Operating Theatres and the Anaesthetic Departments', in Butler (ed.), *Chris McCaffrey*, pp. 269–75.
48. BM, 4 April 1961.
49. Ruth White, 'Chris McCaffrey and the Nursing Staff', in Butler (ed.), *Chris McCaffrey*, pp. 115–25.
50. BM, 22 January 1958.
51. McCaffrey, Functional Management in a Hospital; J. M. Duggan, personal communication.
52. McCaffrey, Functional Management in a Hospital; BM, 20 December 1955.
53. BM, Pharmacy, inpatients, 19 October 1954, outpatients, 5 January 1960; Stationery, 21 September 1954.
54. Meg Thompson, 'The Early Days of Central Sterilizing', in Lewis (ed.), *Reminiscences*, pp. 179–81.
55. McCaffrey, Functional Management in a Hospital, pp. 1, 2.
56. ibid.
57. BM, 5 February 1952.
58. BM, The subject occupied much of the Board minutes between February 1960 and January 1961.
59. BM, 21 June 1960. McCaffrey's statements are found in a summary of a report he made to the Board on his meeting with BMA officials on the one doctor–one hospital issue.
60. ibid.
61. BM, 1 December 1953.
62. BM, 2 August 1960.
63. A. D. Hewson, interview with author, Newcastle, 22 December 1994.

64. Duggan, 'Chris McCaffrey A Pioneer of Quality'.
65. BM, 20 April, 4 May 1954.
66. The first consultant, J. L Forster, was appointed systematist in 1950. BM, 7 November 1950. He was succeeded by Peter Cabban. Peter Cabban, 'Dr C. J. McCaffrey Genius of Hospital Care', in Butler (ed.), *Chris McCaffrey*, pp. 77–103.
67. BM, 15 August 1961; John Greenwell, 'The Chris McCaffrey Connection', in Butler (ed.), *Chris McCaffrey*, pp. 49–59.
68. Butler, 'Chris McCaffrey: An introductory memoir', in Butler (ed.), *Chris McCaffrey*, pp. 13–26. MacEachern was visiting Australia at the invitation of the Australian Hospitals Association and the Governments of the Commonwealth, NSW and Victoria to report on teaching hospitals. This and similar statements have been repeated by many of McCaffrey's admirers but an original has not been sighted.
69. Editorial, *Newcastle Morning Herald and Miners' Advocate*, 20 August 1964.
70. Cyril Renwick, 'Chris McCaffrey and his Hospital', in Butler (ed.), *Chris McCaffrey*, pp. 60–4.
71. *Sydney Morning Herald*, 20 August 1964.
72. Renwick, 'Chris McCaffrey and his Hospital', in Butler (ed.), *Chris McCaffrey*.
73. Butler, 'Chris McCaffrey: An introductory memoir', in Butler (ed.), *Chris McCaffrey*; Morris Owen, interview with author, Sydney, 6 June 1995; Hendry interview; Smyth, 'A Unique Post-Graduate School of Medicine', in Lewis (ed.), *Reminiscences*, pp. 82–95; Duggan, 'Chris McCaffrey, A Pioneer of Quality'.
74. Owen and Hewson interviews.
75. BM, 27 April, 4 May, 18 May 1964.
76. BM, 5 June 1962.
77. Owen interview.
78. Neild, 'The Authoritarian Colossus of the 1930s', in Lewis (ed.), *Reminiscences*; Hendry, Mills and Owen interviews.
79. Gordon Kerridge, 'Question Everything—Especially Facts', in Butler (ed.), *Chris McCaffrey*, p. 173.
80. Owen interview.
81. BM, 7 April 1957; 27 April 1964. Hospital Commission of NSW, Report on the administration of RNH to the Minister for Health, Ministerial correspondence and reports of the Hon. W. F. Sheehan, 1942 to 1966, NSW State Archives, 9/1095.6.
82. BM, 27 April 1964; 4 May 1964; 18 May 1964.
83. Hospital Commission Report.
84. ibid.
85. ibid.
86. R. G. Evans, Paediatrics in NSW 1945 to 1965, PhD thesis, University of Newcastle, 2000, pp. 220–2.
87. Sir Theodore Fox, 'The Antipodes: Private practice publicly supported', *The Lancet*, vol. 1, 1963, pp. 936–8.
88. Hospital Commission Report.
89. ibid.
90. Gordon Kerridge, interview with author, Newcastle, 20 September 1994.
91. Smyth, 'A Unique Post-Graduate School of Medicine', in Lewis (ed.), *Reminiscences*.
92. Bynum, *Science and the Practice of Medicine*, p. 95.
93. Wolfgang Braus, 'German Pediatrics', in Buford L. Nichols, Angel Ballabriga & Norman Kretchmer (eds), *History of Pediatrics 1850–1950,* Nestlé Nutrition, Raven Press, New York, 1991, p. 23.
94. Abraham Flexner, *An Autobiography* (revision of *I Remember*, 1940), Simon & Schuster, New York, 1960, pp. 69, 70.